IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF VIRGINIA
Harrisonburg Division

JOYCE A. CARDIN, Plaintiff, v. NANCY A. BERRYHILL, ACTING COMMISSIONER OF SOCIAL SECURITY, Defendant.	)))))))))	Civil Action No. 5:16-cv-77 REPORT AND RECOMMENDATION By: Joel C. Hoppe United States Magistrate Judge

Plaintiff Joyce A. Cardin asks this Court to review the Acting Commissioner of Social Security's ("Commissioner") final decision denying her application for disability insurance benefits ("DIB") under Title II of the Social Security Act (the "Act"), 42 U.S.C. §§ 401–434. The case is before me by referral under 28 U.S.C. § 636(b)(1)(B). Having considered the administrative record, the parties' briefs and oral arguments, and the applicable law, I find that substantial evidence supports the Commissioner's decision. Therefore, I recommend that the presiding District Judge deny Cardin's Motion for Summary Judgment, ECF No. 12, grant the Commissioner's Motion for Summary Judgment, ECF No. 13, and affirm the Commissioner's final decision.

I. Standard of Review

The Social Security Act authorizes this Court to review the Commissioner's final decision that a person is not entitled to disability benefits. *See* 42 U.S.C. § 405(g); *Hines v. Barnhart*, 453 F.3d 559, 561 (4th Cir. 2006). The Court's role, however, is limited—it may not "reweigh conflicting evidence, make credibility determinations, or substitute [its] judgment" for that of agency officials. *Hancock v. Astrue*, 667 F.3d 470, 472 (4th Cir. 2012). Instead, a court reviewing the merits of the Commissioner's final decision asks only whether the Administrative

Law Judge ("ALJ") applied the correct legal standards and whether substantial evidence supports the ALJ's factual findings. *Meyer v. Astrue*, 662 F.3d 700, 704 (4th Cir. 2011); *see also Riley v. Apfel*, 88 F. Supp. 2d 572, 576 (W.D. Va. 2000) (citing *Melkonyan v. Sullivan*, 501 U.S. 89, 98–100 (1991)).

"Substantial evidence" means "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971). It is "more than a mere scintilla" of evidence, *id*., but not necessarily "a large or considerable amount of evidence," *Pierce v. Underwood*, 487 U.S. 552, 565 (1988). Substantial evidence review takes into account the entire record, and not just the evidence cited by the ALJ. *See Universal Camera Corp. v. NLRB*, 340 U.S. 474, 487–89 (1951); *Gordon v. Schweiker*, 725 F.2d 231, 236 (4th Cir. 1984). Ultimately, this Court must affirm the ALJ's factual findings if "conflicting evidence allows reasonable minds to differ as to whether a claimant is disabled." *Johnson v. Barnhart*, 434 F.3d 650, 653 (4th Cir. 2005) (per curiam) (quoting *Craig v. Chater*, 76 F.3d 585, 589 (4th Cir. 1996)). However, "[a] factual finding by the ALJ is not binding if it was reached by means of an improper standard or misapplication of the law." *Coffman v. Bowen*, 829 F.2d 514, 517 (4th Cir. 1987).

A person is "disabled" if he or she is unable to engage in "any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1505(a). Social Security ALJs follow a five-step process to determine whether an applicant is disabled. The ALJ asks, in sequence, whether the applicant: (1) is working; (2) has a severe impairment; (3) has an impairment that meets or equals an impairment listed in the Act's regulations; (4) can return to

his or her past relevant work based on his or her residual functional capacity; and, if not (5) whether he or she can perform other work. *See Heckler v. Campbell*, 461 U.S. 458, 460–62 (1983); 20 C.F.R. § 404.1520(a)(4). The applicant bears the burden of proof at steps one through four. *Hancock*, 667 F.3d at 472. At step five, the burden shifts to the agency to prove that the applicant is not disabled. *See id.*

II. Procedural History

This is not Cardin's first application for disability benefits. On January 6, 2010, she applied for DIB and alleged a disability onset date of November 29, 2009. Administrative Record ("R.") 74, ECF Nos. 6-1, 6-2. ALJ Drew Swank considered her application and issued an opinion on August 27, 2012, denying her claim. R. 74–81. ALJ Swank determined that Cardin had the residual functional capacity ("RFC")[1] to perform the full range of light work[2] as defined in the regulations. R. 77. Cardin did not appeal this decision, which became the final decision of the Commissioner through August 27, 2012.

Cardin filed the underlying DIB application on December 10, 2013, alleging disability caused by arthritis, lower back problems, hip problems, fibromyalgia, neck problems, high cholesterol, and bilateral foot problems. R. 91. She alleged onset of disability as January 1, 2013, at which time she was fifty-seven years old. *Id.* Disability Determination Services ("DDS"), the state agency, denied her claim at the initial, R. 92–100, and reconsideration stages, R. 102–13. On April 15, 2016, Cardin appeared with counsel and testified at an administrative hearing before ALJ Mark O'Hara. R. 13–50. A vocational expert ("VE") also testified about Cardin's

[1] A claimant's RFC is the most he or she can do on a regular and continuing basis despite his or her impairments. 20 C.F.R. § 404.1545(a); SSR 96-8p, 1996 WL 374184, at *1 (July 2, 1996).

[2] "Light" work involves lifting no more than twenty pounds at a time, but frequently lifting objects weighing ten pounds. 20 C.F.R. § 404.1527(b). A person who can meet these lifting requirements can perform light work only if she also can "do a good deal of walking or standing, or do some pushing and pulling of arm or leg controls while sitting." *Hays v. Sullivan*, 907 F.2d 1453, 1455 n.1 (4th Cir. 1990).

past relevant work, both as actually performed and as generally performed in the national economy. R. 41–49. The VE explained that Cardin's past relevant work as a maid was generally performed at the light level, but it was medium exertional work as Cardin actually performed it. R. 46.

On July 26, 2016, ALJ O'Hara issued a written decision denying Cardin's DIB claim. R. 54–65. The ALJ first determined that Cardin's date last insured ("DLI") was December 31, 2014, and that Cardin had not engaged in substantial gainful activity since her alleged onset date.[3] R. 56. He then found that Cardin had severe impairments of spine disorder and fibromyalgia. *Id.* All other impairments, including plantar fasciitis, heel spurs, gastroesophageal reflux disease, and depression, were deemed non-severe. R. 57–58. None of these impairments, either alone or in combination, met or medically equaled a listed impairment. R. 58–59. As to Cardin's RFC, ALJ O'Hara determined that she could perform light work as defined in the regulations, except that she could frequently stoop and occasionally climb ladders, ropes, or scaffolds. R. 60. Cardin could perform other postural activities, including balancing, kneeling, crouching, crawling, and climbing ramps and stairs, without limitation. *Id.* Based on this RFC finding and the testimony of the VE, the ALJ concluded that Cardin could perform her past relevant work as a housekeeper/maid as generally performed in the national economy. R. 64. Therefore, ALJ O'Hara concluded that Cardin was not disabled between January 1, 2013, and December 31, 2014. R. 64–65. The Appeals Council denied Cardin's request for review, R. 1–3, and this appeal followed.

III. Discussion

[3] To qualify for DIB, Cardin "must prove that she became disabled prior to the expiration of her insured status." *Johnson*, 434 F.3d at 656; *see* 42 U.S.C. § 423(a)(1)(A), (c)(1)(B); 20 C.F.R. § 404.131 (2015).

Cardin challenges ALJ O'Hara's evaluation of the medical-source opinion evidence, specifically his treatment of the assessments offered by Kayde Guenthner, N.P., and Don R. Martin, M.D., a rheumatologist. Pl.'s Br. 2, ECF No. 11. Cardin asserts that the ALJ "failed to give sufficient consideration" to both opinions, which identified more restrictive limitations than those in ALJ O'Hara's RFC determination. *Id.* The Commissioner contends that Cardin's argument is essentially a request that the Court reweigh evidence the ALJ already considered, and that ALJ O'Hara adequately explained why he discounted these medical-source opinions. Def.'s Br. 16–19, ECF No. 14. The Commissioner has the better position.[4]

A. Background

[4] Cardin makes three additional unconvincing arguments that merit little discussion. First, she asserts that the ALJ did not consider the combination of her impairments when assessing whether she met "the listings or combination of listings," but Cardin does not identify the evidence she contends is relevant to the listings-level analysis—much less which Listing(s) she believes she met before December 31, 2014. *See* Pl.'s Br. 1–2; R. 58. Meeting a Listing requires strict compliance. *See Sullivan v. Zebley*, 493 U.S. 521, 530 (1990) ("For a claimant to show that his impairment matches a listing, it must meet *all* of the specified medical criteria. An impairment that manifests only some of those criteria, no matter how severely, does not qualify."). ALJ O'Hara discussed the Listings relevant to Cardin's fibromyalgia, including Listings 1.00 (musculoskeletal disorders), 11.00 (neurological disorders), and 14.00 (immune system disorders), and explained why the evidence did not establish that she met or medically equaled all the criteria for any of these Listings. R. 58–59. The discussion of Listing 1.00 was also applicable to Cardin's severe impairment of spine disorder. R. 59. In the absence of any argument from Cardin showing a specific deficiency in the ALJ's discussion, and having reviewed the record, I cannot find his step-three analysis wanting. *See Reid v. Comm'r of Soc. Sec.*, 769 F.3d 861, 865 (4th Cir. 2014).

Second, Cardin claims that the ALJ erred by not having her evaluated in person by a physician, counselor, or psychiatrist prior to her hearing. Pl.'s Br. 2. The ALJ retains the discretion to order, or not order, a consultative examination on an individual basis in accordance with the regulations. *See* 20 C.F.R. §§ 404.1519, 404.1519a(a). That said, the ALJ must consider all the evidence, including the claimant's allegations, and "a consultative examination *must* be ordered when there is insufficient evidence to support the claim." *Kersey v. Astrue*, 614 F. Supp. 2d 679, 694 (W.D. Va. 2009). Here, the record before ALJ O'Hara appears sufficient to have allowed him to meaningfully consider Cardin's medical conditions and claimed limitations. Thus, ALJ O'Hara did not err by not ordering a consultative examination of Cardin. *See Johnson v. Astrue*, No. 6:11cv9, 2012 WL 2046939, at *3 (W.D. Va. June 5, 2012).

Third, Cardin asserted at oral argument that the ALJ did not take into consideration her advanced age, limited education, and lack of transferrable skills in making his decision. Be that as it may, ALJ O'Hara concluded at step four that Cardin could return to her past work as customarily performed. R. 64–65. In such a scenario, the ALJ did not need to consider these vocational factors. 20 C.F.R. § 404.1560 (explaining that when the ALJ determines that a claimant can do her past relevant work, he "will not consider [the claimant's] vocational factors of age, education, and work experience").

1. Relevant Medical Evidence

Cardin presented to Dr. Martin on January 3, 2013, for an initial consultation. R. 734–40. At the time, she experienced morning stiffness for "1/2 hour(s)," but "[p]ertinent negatives include[d] medicine side effects [and] swelling. R. 734. Cardin reported "articular pain [in her] cervical and lumbar spine, bilateral hips, and right knee since 2000"; "right elbow and hand 'paresthesias,'" which sometimes woke her up at night; right leg numbness, but no diagnosis of sciatica; left leg aching "in the setting of varicosities"; initial and terminal insomnia; and generalized musculoskeletal pain and tenderness, such that a "bear hug" was painful. *Id.* On physical examination, she was in no acute distress. R. 738. She had no cervical adenopathy. *Id.* Her spine exam was negative for posterior tenderness, and a sitting straight leg raise test was negative. R. 739. Dr. Martin noted that her cervical spine range of motion was "limited in all 3 planes – but with local rather than radicular discomfort." *Id.* Abduction in the shoulders was 90 degrees bilaterally. *Id.* Her joints were uniformly cool throughout, and she displayed 10/18 tender points. *Id.* Cardin displayed no motor weakness, her balance and gait were intact, Tinel's sign was negative bilaterally, and Phalen sign was positive on the right. *Id.* Dr. Martin assessed osteoarthritis and fibromyalgia. *Id.* Cardin followed up with Dr. Martin on January 28 and reported that her "neck, back and 'legs' remain most symptomatic." R. 509. Her physical examination was unchanged, except that she now displayed 16/18 tender points. R. 512. Dr. Martin continued her on a rheumatic regimen, prescribed Lidoderm patches, recommended gradually increasing her weight-bearing aerobic exercise, discussed injections and additional medications, and refilled her Percocet. R. 512–13.

Cardin followed up with David Lee, M.D., on March 19, 2013, and had no complaints. R. 460. Cardin said that her rheumatologist had started her on Cymbalta 30mg two weeks earlier,

and she wanted to know if Dr. Lee would take over management of the Percocet that her orthopedist had prescribed. *Id.* Dr. Lee declined Cardin's request, and instructed her to continue under the orthopedist's care. R. 460–61. Cardin had no deformities, clubbing, cyanosis, or edema in the extremities and no musculoskeletal change. R. 461. Dr. Lee assessed unspecified myalgia/myositis and noted that he thought Cardin would benefit from increasing her Cymbalta. *Id.* Cardin next treated with Justin Nolen, P.A., on April 4, 2013, for her lumbar spine pain and neck pain. R. 648–53. Her lower back pain radiated to her right lower extremity and was relieved by medications such as Tramadol; her neck pain had improved on Cymbalta and was relieved by using a heating pad. R. 650. On physical examination, she displayed normal weight-bearing gait, normal posture, normal lower extremity muscle tone, normal paraspinous muscle tone, and normal bilateral lower extremity strength, but she endorsed maximum tenderness to palpation at "lumbar, paraspinous," pain with motion, back pain on the left and radiating pain on the right with straight leg raise test, and PA Nolen had difficulty eliciting deep tendon reflexes in the lower extremities. R. 651–52. PA Nolen assessed lumbar degenerative disc disease, lumbar spondylosis, and lumbar radiculitis, and he ordered imagining studies of her back. R. 652. During a follow up on April 15, PA Nolen noted that recent imaging revealed degenerative disc disease with protrusion at L4-5 and Tarlov cysts in the sacral region, but no specific nerve root compression or evidence of a tethered spinal cord. R. 665; *see also* R. 463–64 (MRI revealing "disc degeneration with mild posterior disc bulge at L4-L5. There are no focal disc protrusions. Mild degenerative changes of the facet joint at L5-S1 on the left."); R. 465 (X-ray of the lumbar spine revealing "lumbar degenerative disc disease and degenerative joint disease"). PA Nolen ordered a "lumbar epidural at the L4-5 level," R. 668, which Cardin underwent on April 24, R. 462. Cardin followed up with PA Nolen on May 1 and complained of fluctuating, but persistent,

lower back pain. R. 673. Cardin explained that she experienced right leg tingling, numbness, and weakness and that she received no relief from the injection. *Id.* She also had tightness and stinging in her neck. *Id.* Cardin's physical examination was unchanged from the previous visit. R. 674–75. PA Nolen renewed her pain medication and recommended a "comprehensive pain evaluation via pain management." R. 675.

Cardin followed up with Dr. Martin on June 14, 2013. R. 503–08. She reported improvement in her initial and terminal insomnia, her generalized pain and tenderness, and her neck, back, and legs. R. 503. She did not find the Lidoderm patches or the lumbar epidural injection beneficial. *Id.* Findings on physical examination remained the same, except that she displayed 6/18 tender points. R. 506–07. Dr. Martin assessed osteoarthritis and fibromyalgia, continued her on her current rheumatic regimen, increased her duloxetine (Cymbalta) from 30 mg to 60 mg twice daily, and instructed her to follow up in six months. R. 507. Cardin returned on December 13. R. 499–502. She explained that her osteoarthritis remained symptomatic in her lower back and her insomnia and generalized pain and tenderness persisted. R. 499. She could not tolerate the increase in duloxetine, and she had applied for medical assistance with a local hospital. *Id.* Dr. Martin observed no changes on physical examination, R. 501, and he did not change his assessment, R. 502. Per his instructions, Cardin followed up six months later on June 12, 2014. R. 902–06. She reported that she was "not so good" and was intermittently tearful. R. 902. On physical examination, Dr. Martin observed that she was in moderate distress, had no posterior tenderness in the back/spine, had negative straight leg raise test both sitting and extended, had uniformly cool joints throughout, and had 16/18 tender points. R. 905. He continued her previous medications and instructed her to follow up in six months. R. 906.

Cardin's final treatment during the relevant period occurred on July 9, 2014, when she presented to Valley Vascular Associates regarding varicose veins. R. 918–20. The review of systems was positive for urinary frequency, back pain, joint pain, joint swelling, muscle weakness, neck pain, gait disturbance, headache, heartburn, nausea, and vomiting. R. 918–19. Cardin also reported that she had worn prescription-strength compression stockings for the previous four years, but recently had not been using them consistently. R. 919. She also noted difficulty walking and standing for more than two hours because of discomfort. *Id.* A physical examination revealed grossly intact light sensation in the upper and lower extremities bilaterally; "decent strength bilaterally with handgrips and ankle dorsiflexion and plantar flexion"; no significant edema; and some varicosities on her lower left leg and her right lower leg. R. 920. It was noted that Cardin's lack of medical insurance complicated her treatment, and she was provided with a prescription for new compression stockings. *Id.*

Cardin continued her treatment after her December 31, 2014 DLI. She saw Dr. Martin on two more occasions. R. 954–61 (Feb. 4, 2015), R. 966–72 (May 26, 2015). During both visits, Cardin reported similar symptoms as she had during previous visits. Dr. Martin observed 10/18 tender points both times. R. 959, 971. On February 4, Cardin reported that she had stopped taking duloxetine "due to perceived lack of benefit." R. 954. Dr. Martin discontinued that prescription and renewed Cardin's prescription for Tramadol. R. 959–60. On March 15, 2016, Dr. Martin completed an assessment of Cardin's functioning. R. 1023–27. Dr. Martin explained that Cardin's musculoskeletal complaints stemmed from osteoarthritis and fibromyalgia, specifically that the osteoarthritis caused localized pain whereas the fibromyalgia resulted in generalized pain and tenderness. R. 1023–24. He opined that Cardin could not perform any bending, stooping, reaching, standing, sitting, lifting, walking, running, gripping, or pulling, or

was, at best, very limited in performing these activities. R. 1025. Dr. Martin noted that Cardin could sit in one position for one to two hours (but not all at one time), could stand for one to two hours (but not all at one time), and could frequently lift five to ten pounds during an eight-hour workday. *Id.* Dr. Martin stated that she could not work a forty-hour week, she was permanently disabled, and, given that Cardin "last worked prior to [their] first meeting in January 2013," he believed her medical conditions became disabling around the same time. *See* R. 1026–27.

Cardin also sought treatment with NP Guenthner beginning on January 12, 2015, and Cardin primarily complained of symptoms associated with depression. R. 985–86. Cardin saw with NP Guenthner at least four more times through February 2016. R. 993–94 (Mar. 2, 2015), 1001–02 (Nov. 11, 2015), 1010–11 (Jan. 7, 2016), 1019–20 (Feb. 16, 2016). She complained of chronic neck and low back pain during each visit; physical examinations were mostly normal with no edema, but some tenderness and decreased range of motion in the lumbar spine; and NP Guenthner assessed sciatica and prescribed a prednisone taper as well as a small number of hydrocodone-acetaminophen to take as needed for severe pain. *Id.* On February 17, 2016, NP Guenther completed an evaluation of Cardin's functioning. R. 936–40. NP Guenthner explained that she observed chronic lower back pain, chronic neck pain, and depression, all of which contributed to Cardin's symptoms. R. 937. Cardin tired easily, and she could not bend, stoop, or squat. R. 938. She was unable to sit or stand for longer than thirty minutes at a time because of increased lower back and neck pain, and she could sit and stand for less than an hour each during an eight-hour workday. *Id.* Cardin could lift no more than five pounds frequently during an eight-hour workday. *Id.* NP Guenthner explained that these limitations dated back to 2010 and that Cardin was permanently disabled. R. 939–40.

2. DDS Medical Opinions

Lewis Singer, M.D., assessed Cardin's functioning as part of the initial review of her DIB application. R. 92–98. Dr. Singer noted severe impairments of spine disorders and fibromyalgia. R. 96. Dr. Singer opined that during an eight-hour workday, Cardin could lift and/or carry twenty pounds occasionally and ten pounds frequently; sit about six hours and stand and/or walk about six hours; and could push and/or pull on an unlimited basis, other than as shown for lift and carry. R. 97. Dr. Singer also concluded that Cardin could climb ladders, ropes, or scaffolds occasionally; stoop frequently; and balance, kneel, crouch, crawl, and climb ramps and stairs on an unlimited basis. *Id.* Dr. Singer did not assess any other limitations. R. 97–98. On reconsideration review, Robert McGuffin, M.D., affirmed Dr. Singer's findings. R. 103–11.

3. Cardin's Report of Symptoms and Testimony

Cardin completed one function report as part of her application for benefits. R. 222–29. She stated that she lived in a house with family, and on a normal day, she tried to do various tasks around the house, but needed to sit down and rest about every half hour. R. 222. She did not take care of anyone else and had no difficulty with personal care, but pain affected her sleep. R. 223. She prepared her own meals daily, but could no longer prepare big meals for her family. R. 224. She did light housework, such as washing clothes in the machine, but did not do any heavy work, yardwork, or repairs. *Id.* She could drive a car, and she shopped for food at the store once a week with her son. R. 225. Her hobbies and interests included watching television and reading, which she did every day. R. 226. She only went to church and the store regularly. *Id.* She indicated difficulty with lifting, squatting, bending, standing, reaching, walking, sitting, kneeling, climbing stairs, completing tasks, concentrating, and using her hands. R. 227. She could lift only five pounds; could do some squatting and bending with pain; could not stand on her feet for a long time; could not reach for long periods of time; and could walk 300 feet before

needing to stop and rest for fifteen minutes. *Id.* She used a brace/splint. R. 228. Cardin, who was right handed, could hardly use her right hand at all. R. 228–29.

At the administrative hearing, Cardin testified that she lived in a two-story house with her husband and thirty-two-year-old son. R. 32, 38. She left school during the eighth grade, R. 33, and she did not know how to use a computer. R. 35. Her fibromyalgia and osteoarthritis pain started in her neck, but went down into her shoulder blades, right arm, lower back, and left leg to her foot. R. 23. She could not sit or stand for any significant period. R. 24–25. Hydrocodone helped, but "not a whole lot," and she needed to take Aleve and use a heating pad an hour and a half after taking the hydrocodone. R. 24. Cardin did not sleep well, and she reclined during the day and took naps. R. 25. She also got acid reflux, had to go to the bathroom to urinate every fifteen to twenty minutes, suffered frequent headaches, and was depressed. R. 26, 29. She had tried physical therapy and injections, which did not alleviate her pain, and she had been referred for pain management. R. 31. She could drive to the store, which was seven miles away, but she was afraid to drive, and her son did most of the driving. R. 23, 33. She stated that her son helped out a lot and that she did not "know what [she] would do without him." R. 33.

B. Analysis

Cardin challenges ALJ O'Hara's treatment of Dr. Martin's and NP Guenthner's opinions, which the ALJ analyzed together and rejected, R. 63. Medical opinions are statements from "acceptable medical sources," such as physicians, that reflect the source's judgments about the nature and severity of the claimant's impairment, including her symptoms, diagnosis and prognosis, functional limitations, and remaining abilities. 20 C.F.R. § 404.1527(a)(1). The regulations classify medical opinions by their source: those from treating sources and those from non-treating sources, such as examining physicians and state-agency medical consultants. *See id.*

§ 404.1527(c). The medical opinion of a treating physician, such as Dr. Martin, "is entitled to controlling weight if it is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the record." *Mastro v. Apfel*, 270 F.3d 171, 178 (4th Cir. 2001); *see also* 20 C.F.R. § 404.1527(c)(2). An ALJ may choose to assign a treating physician's opinion less than controlling weight, however, if there is "persuasive contrary evidence" in the record. *Hines*, 453 F.3d at 563 n.2; *Mastro*, 270 F.3d at 178. In doing so, the ALJ must "give good reasons" for the weight assigned. *See* 20 C.F.R. § 404.1527(c)(2). Furthermore, the ALJ must consider all relevant factors, including the relationship—in terms of length, frequency, and extent of treatment—between the doctor and the patient, the degree to which the opinion is supported or contradicted by other evidence in the record, the consistency of the opinion with the record as a whole, and whether the treating physician's opinion pertains to his or her area of specialty. *Id.*

As a family nurse practitioner, NP Guenthner is a non-acceptable medical source, and therefore her opinion does not constitute a "medical opinion" as that term is defined by the regulations. 20 C.F.R. § 404.1513(d)(1) (2016). That said, although non-acceptable medical sources cannot give "medical opinions" about the claimant's condition, *see Ward v. Chater*, 924 F. Supp. 53, 56 (W.D. Va. 1996), they can provide valuable information about the claimant's medical condition and functional limitations, and the ALJ must consider that information as he would any relevant evidence, *Adkins v. Colvin*, No. 4:13cv24, 2014 WL 3734331, at *3 (W.D. Va. July 28, 2014). Indeed, the ALJ may consider opinions from non-acceptable medical sources as he would opinions from acceptable medical sources, especially when the source "had a lengthy relationship with the claimant." *Adkins*, 2014 WL 3734331, at *3 n.6 (quoting *Hall v. Colvin*, No. 7:12cv327, 2014 WL 988750, at *8 (W.D. Va. Mar. 13, 2014)). When reviewing the

ALJ's evaluation of the opinion evidence, the Court "must defer to the ALJ's assignments of weight unless they are not supported by substantial evidence." *Dunn v. Colvin*, 607 F. App'x 264, 271 (4th Cir. 2015).

Here, ALJ O'Hara rejected both NP Guenthner's and Dr. Martin's opinions that Cardin was "unable to do even sedentary work." R. 63. He found that their opinions were "not supported by the longitudinal record with its limited physical findings and routine and conservative treatment, including their own treatment notes . . . . The assessments prepared by Ms. Guenthner and Dr. Martin [were] based on the claimant's reported symptoms and limitations, rather than on objective findings and diagnostic test results." *Id.* The ALJ also explained that NP Guenthner was not an acceptable medical source, her opinion was dated over a year after the DLI, she related Cardin's limitations back to 2010 even though she first treated Cardin in January 2015, and she recorded "generally unremarkable physical examination findings on routine follow-up on 3 occasions in 2015." *Id.* Moreover, ALJ O'Hara explained that Cardin's treatment with Dr. Martin was generally "routine and conservative with gaps in treatment and recommended visits generally only every 6 months . . . . [H]e has reported generally unremarkable examination findings. Other than tender points, Dr. Martin's exams revealed negative straight leg raising and that the claimant was neurologically intact with normal gait and balance." *Id.*

Cardin, notably, does not challenge any specific aspect of ALJ O'Hara's evaluation of the opinion evidence, but rather simply posits that he "failed to give sufficient consideration to" either opinion and as such her case should be remanded.[5] Pl.'s Br. 2. ALJ O'Hara's evaluation of

[5] The Commissioner asserts that "[a]s a threshold matter, [all] Plaintiff's arguments are waived on appeal" because "Plaintiff sets forth no argument consisting of more than two sentences, and essentially only lists her arguments." Def.'s Br. 9. The Court's local rules require the plaintiff to file "a brief addressing why the Commissioner's decision is not supported by substantial evidence or why the decision otherwise should be reverse or the case remanded." W.D. Va. Gen. R. 4(c)(1). Although the Commissioner is

the opinion evidence, however, is supported by substantial evidence and must be affirmed. *Dunn*, 607 F. App'x at 271; *see also Carr v. Berryhill*, No. 6:16cv10, 2017 WL 4127662, at *5 (W.D. Va. Sept. 18, 2017) ("The Court cannot simply look at the same evidence and reverse the ALJ on the basis that [he] could have reached a different result.").

First, Dr. Martin's and NP Guenthner's physical examinations were generally unremarkable. R. 63; *see Bishop v. Comm'r of Soc. Sec.*, 583 F. App'x 65, 67 (4th Cir. 2014) (per curiam) (substantial evidence supported ALJ's decision to reject treating physician's opinion "in its entirety" where the opinion was "inconsistent with the mild to moderate diagnostic findings . . . and the generally normal findings during physical examinations"). Dr. Martin consistently observed negative straight leg raising tests, normal gait and balance, no edema, no motor weakness, no cervical adenopathy, and no posterior tenderness in the spine. R. 501, 506–07, 738–39. Although he observed 16/18 tender points on two occasions, R. 512, 905, Dr. Martin observed 10/18 tender points during three visits, R. 739, 959, 971, and 6/18 tender points during the other two visits, R. 501, 507.[6] NP Guenthner did not make any relevant findings on physical examination during the first two visits. *See* R. 985, 993. In November 2015, NP Guenthner observed some tenderness in the lumbar paraspinal musculature bilaterally, but Cardin had no edema and no deformity in her back. R. 1002. A visit in January 2016 revealed

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correct that Cardin's brief fails to develop any of her arguments, it does not constitute a waiver of all of them.

That said, Cardin's general statements that the "Administrative Law Judge and Appeals Council did not consider the combined effects of the exertional and non-exertional impairments of the Plaintiff in determining her eligibility for work" and that the ALJ's finding "that the Plaintiff was not disabled was not based upon substantial evidence," Pl.'s Br. 2, represent no more than a generic disagreement with the RFC and do not set forth any argument that explains *why* she disagrees with the Commissioner's decision as required by the Court's local rules. *Cf. Beaudett v. City of Hampton*, 775 F.2d 1274, 1278 (4th Cir. 1985) (noting that district courts never are required "to conjure up questions never squarely presented to them"). As such, I will only address Cardin's challenge to the ALJ's evaluation of the opinion evidence.

[6] Notably, a diagnosis of fibromyalgia based in part on tender points requires at least 11/18 positive tender points. *See* SSR 12-2p, 2012 WL 3104869, at *2–3 (July 25, 2012).

right-sided lumbar paraspinal musculature tenderness, but also no edema and no deformity. R. 1010. Additionally, notes from other providers revealed generally unremarkable physical examinations during the relevant period. Dr. Lee noted no edema in March 2013. R. 461. PA Nolen observed normal posture, gait, and lower extremity strength and muscle tone on multiple occasions. R. 651–52, 667, 674–75. Providers at Valley Vascular Associates saw no edema and grossly intact sensation in July 2014. R. 920. Moreover, the Court does not reweigh conflicting evidence, *Davis v. Barnhart*, 392 F. Supp. 2d 747, 751 (W.D. Va. 2005) (citing *Smith v. Chater*, 99 F.3d 635, 638 (4th Cir. 1996)), and here, the ALJ's conclusion that Cardin's physical examinations revealed generally normal findings is borne out by the record.

Similarly, ALJ O'Hara explained that both Dr. Martin's and NP Guenthner's opinions appeared to have been based on Cardin's subjective statements, rather than on the objective findings, which, as noted above, were relatively benign. R. 63. ALJ O'Hara conducted a thorough evaluation of Cardin's report of symptoms. R. 61–63. He noted that she had not received the type of treatment one would expect for an individual asserting a completely disabling condition; she had gaps in her treatment history; she did not seek out recommendations such as pain management referrals; she had overwhelmingly normal physical examinations; and her testimony was not fully consistent with the record. *Id.* This reasoning, combined with the discussion of Cardin's treatment history, provides ample support for the ALJ to question the claimed severity of her symptoms. Cardin does not challenge this assessment. As such, it was within the ALJ's discretion to question these medical-source opinions that appeared to rely on the patient's report of symptoms, especially where, as here, the ALJ found the claimant less than credible. *Weaver v. Colvin*, No. 3:15cv26, 2016 WL 4768841, at *11 (W.D. Va. Sept. 13, 2016); *see also Morris v. Barnhart*, 78 F. App'x 820, 824–25 (3d Cir. 2003) (explaining that an ALJ

may properly discredit a physician's findings that were premised largely on the claimant's own accounts of his symptoms and limitations when the claimant's complaints are properly discounted); *Craig*, 76 F.3d at 590 n.2 (noting that it is well-settled that a doctor does not transform a patient's subjective complaints into objective medical evidence simply by recording them in his treatment notes).

Cardin's treatment was also routine and conservative, and the ALJ was permitted to consider the nature of this treatment in evaluating the weight he assigned to the opinion evidence, *see* 20 C.F.R. § 404.1512(b)(ii) (2016); *see also Johnson*, 434 F.3d at656–57; *Wittig v. Colvin*, No. 5:15cv66, 2017 U.S. Dist. LEXIS 8477, at *37–39 (W.D. Va. Jan. 23, 2017), *adopted by* Order, ECF No. 27 (W.D. Va. Mar. 22, 2017). ALJ O'Hara explained that "no surgery was recommended, and there was no ongoing treatment by a neurologist [or] pain management specialist, . . . as well as no follow-up treatment with an orthopedist after May 2013," and that Cardin treated primarily with medications, physical therapy—which she did not complete—prior to the alleged onset date, and a single lumbar epidural steroid injection. *Id.* Similar treatment has been considered "conservative" for physical impairments, such as Cardin's spine disorder, *see Dunn*, 607 F. App'x at 272–75; *Gregory v. Colvin*, No. 4:15cv5, 2016 WL 3072202, at *5 (W.D. Va. May 6, 2016) ("It was reasonable for the ALJ to characterize [Plaintiff's] course of treatment, consisting of pain medication, physical therapy, and steroid injections, as 'conservative.'"), *adopted by* 2016 WL 3077935 (W.D. Va. May 31, 2016), and her fibromyalgia, *see Burger v. Colvin*, No. 7:14cv190, 2015 WL 5347065, at *7 (W.D. Va. Sept. 14, 2015) ("Dr. Lemmer's notes do not suggest that he had trouble controlling Burger's fibromyalgia or that he was experimenting with varying treatment; his notes suggest less and less

frequent appointments, a fairly standard medication routine, and no use of more severe treatments such as trigger point injections.").

Relatedly, as the ALJ indicated, Cardin treated with Dr. Martin on a limited basis with follow-up appointments every six months. R. 63. Other than her next appointment after the initial consultation, Dr. Martin did not recommend that Cardin return on a more frequent basis. ALJ O'Hara could reasonably determine that this biannual treatment, coupled with the benign examination findings and conservative treatment, undermined Dr. Martin's later opinion espousing more extreme limitations. *Cf. Hunter v. Sullivan*, 993 F.2d 31,36 (4th Cir. 1992) (finding that a failure to seek "sustained" or "ongoing" treatment can support an ALJ's inference that a claimant's symptoms are not as severe as she asserts); *Burke v. Berryhill*, No. 5:15cv74, 2017 WL 1133508, at *8 (W.D. Va. Mar. 24, 2017) (concluding that it was reasonable for the ALJ to determine that sporadic treatment—once every nine months—along with normal exam findings and conservative treatment was inconsistent with the claimant's report of debilitating symptoms).

Lastly, although Dr. Martin and NP Guenthner claimed that the limitations identified in their opinions dated back to before Cardin's alleged onset date, their contemporaneous treatment notes do not support these conclusions. Again, Dr. Martin made relatively normal findings during his treatment of Cardin, which began on January 3, 2013. R. 734. As for NP Guenthner, the record does not reveal any treatment notes from her until January 2015, R. 985, and she did not opine on Cardin's physical status until November 2015, R. 1001–02. The ALJ thus properly noted that NP Guenthner's opinion arguably did not even relate to the relevant period.[7] R. 63.

[7] At oral argument, Cardin explained that although NP Guenthner did not begin treating her until January 2015, she had been treating with a different nurse—Marie Jackson, N.P.—at the same practice throughout the relevant period. Cardin argued that NP Guenthner's opinion could therefore relate back to 2010 because it was a continuation of treatment supported by NP Jackson's treatment notes. NP Jackson's

Overall, Cardin simply challenges ALJ O'Hara's rejection of the opinions of her healthcare providers, but she does not identify any specific deficiencies in his decision. The ALJ rejected these opinions because, at base, they were "not supported by the longitudinal record." *Id.* The ALJ then provided numerous, more specific reasons in support of this conclusion, a discussion which is supported by substantial evidence. Therefore, Cardin's challenge must fail, and ALJ O'Hara's decision must be affirmed.

IV. Conclusion

For the foregoing reasons, I find that substantial evidence supports the Commissioner's final decision. Accordingly, I respectfully recommend that Cardin's Motion for Summary Judgment, ECF No. 12, be **DENIED**, the Commissioner's Motion for Summary Judgment, ECF No. 13, be **GRANTED**, the Commissioner's final decision be **AFFIRMED**, and this case be **DISMISSED** from the Court's active docket.

Notice to Parties

Notice is hereby given to the parties of the provisions of 28 U.S.C. § 636(b)(1)(C):

> Within fourteen days after being served with a copy [of this Report and Recommendation], any party may serve and file written objections to such proposed findings and recommendations as provided by rules of court. A judge of the court shall make a de novo determination of those portions of the report or specified proposed findings or recommendations to which objection is made. A judge of the court may accept, reject, or modify, in whole or in part, the findings or recommendations made by the magistrate judge. The judge may also receive further evidence or recommit the matter to the magistrate judge with instructions.

Failure to file timely written objections to these proposed findings and recommendations within 14 days could waive appellate review. At the conclusion of the 14 day period, the Clerk is directed to transmit the record in this matter to the Honorable Elizabeth K. Dillon, United States District Judge.

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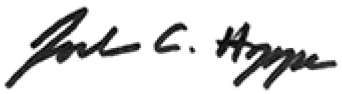
notes come primarily from before the relevant period, *see* R. 370–72, 444–51, 565–66, and this continuing treatment does not alter the ALJ's otherwise sufficient analysis of NP Guenthner's opinion.

The Clerk shall send certified copies of this Report and Recommendation to all counsel of record.

ENTER: January 30, 2018



Joel C. Hoppe
United States Magistrate Judge